

## Advisory Committee on Data Issues meeting minutes

January 31, 2022  
Health Care Authority  
Meeting held electronically (Zoom) and telephonically  
10:00 a.m. – 12:00 p.m.

**Note:** this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the [Health Care Cost Transparency Board webpage](#).

### Members present

**Board Members:**

Allison Bailey  
Amanda Avalos  
Ana Morales  
Bruce Brazier  
David Mancuso  
Hunter Plumer (joined at 10:41)  
Jerome Dugan  
Jonathan Bennett  
Josh Liao  
Julie Sylvester  
Leah Hole-Marshall (joined at 10:48)  
Lichiou Lee  
Mark Pregler  
Megan Atkinson  
Purav Bhatt  
Scott Juergens

**Members absent:**

Jason Brown

### Agenda items

#### Welcome, Roll Call, Agenda Review

AnnaLisa Gellermann, committee facilitator, called the meeting to order at 10:02 a.m.

#### Approval of Minutes

AnnaLisa Gellermann provided a recap of the October Committee meeting, and the Committee approved the October meeting minutes.



## Topics for Today

Topics relating to the cost growth benchmark measurement, reporting, and analysis presented to the Committee included the following:

- Review meeting plan for Year 2.
- Discuss analysis of cost and cost growth drivers
- Review pre-benchmark data collection plan and timeline
- Review payer survey of provider entity contracts
- Wrap up discussion on benchmark performance assessment

## Meeting Plan for Year 2

Michael Bailit, Bailit Health  
PowerPoint presentation

Mr. Bailit presented to the Committee an overview of intended activities for the following year.

## Analyses of cost and cost growth drivers

Michael Bailit, Bailit Health  
PowerPoint presentation

Michael Bailit of Bailit Health reminded the Committee of the difference between the cost benchmark analysis (aggregate data allowing for benchmark performance at several levels) and the cost driver analysis (granular claims and encounter data to analyze cost and cost growth). The purpose of the cost driver analysis is to determine where spending is problematic, determine what is causing the problem, and identify accountable entities. The presentation identified two phases of cost driver analyses. Phase one consists of standard analytic reports produced on an annual basis at the state and market levels. Phase two will contain supplemental in-depth analyses developed based on results from standard reports and Board discussion.

HCA staff proposed the following areas for initial reports: spend and trend, stratified by geographic rating area; impact of price and utilization on spending; spend and trend by health condition; spend and trend by demographic. Work would need to be done in all areas to further refine appropriate variables. HCA staff also propose monitoring of potential unintended adverse consequences in the areas of quality, access, and provider composition. These analyses would be reported at the state and market levels. Bailit presented analyses in these areas from other states.

Committee members asked about the overlap between the cost benchmark data and the cost driver analysis. Mr. Bailit responded that the two analyses would not show identical trend rates, as the cost benchmark analysis includes significant data elements not included in the APCD. But the two analyses should work together to provide greater insight. The Committee asked whether price and utilization would be combined, and Mr. Bailit responded that initially it would be likely but that opportunities for stratification would be available and could be pursued. One Committee member mentioned that WHA reports include intensity, and other states are looking to adopt the same process. One Committee member noted that the CMS chronic condition warehouse data should be considered as an option. A question was raised about whether pediatric conditions could or should be considered independently from adult conditions, and Mr. Bailit responded that these analyses were certainly possible. One Committee member asked if geographic areas had been specified and supported use of the 9 insurance rating areas as coinciding with price. Mr. Bailit responded that the statute required rating regions, but that there would be flexibility. Some Committee members agreed that the initial approach seemed reasonable.



## Public Comment

There was no public comment.

## Review pre-benchmark data collection plan and timeline

Ross McCool, Health Care Authority

Mr. McCool presented to the Committee an overview of the timeline for the benchmark data collection. Payer seminars and office hours will be held in May and June, and a request for preliminary data submission will be open on June 30. More information will be provided over the next months.

## Review payer survey of provider entity contracts

Ross McCool, Health Care Authority

Mr. McCool described the upcoming payer survey that would be sent to payers. The purpose of the survey is to ensure that the Board has correctly identified the larger provider entities that will be the subject of benchmark reporting. Payers will be asked to identify those provider entities with whom they have total cost of care contracts. The survey is expected to go out in the end of February.

## Wrap up discussion on benchmark performance assessment

January Angeles, Bailit Health

Ms. Angeles resented information to the board on benchmark performance assessment, including truncation and risk adjustment. For measurement at the insurer and provider entity level, the Board had previously decided to truncate spending on high-cost outliers at a to-be-determined threshold. Specifically, Ms. Angeles sought feedback on what the truncation thresholds should be and whether they should vary by market. HCA proposed an approach consistent with Rhode Island, with the following threshold: Commercial, \$150k, Medicaid, \$250k, and Medicare, \$100k. Two members shared that the limits appear high, especially when risk-sharing contracts are involved, with concern that too many claims would be excluded. One member shared that he had observed large variability in claims thresholds. In response to a question, Ms. Angeles clarified that truncation amounts would be valued at the member level, cumulatively (rather than at the treatment level), and that it would be applied to the analysis of provider groups and insurers by market. Truncation would not be applied at the state and market level analyses. The committee indicated that Washington specific data on the impact of truncation levels would be supportive in decision-making. The group also recommended an approach that would permit reviewers to understand what had been excluded (either through the ability to “toggle” the truncation on and off, or through an ad-hoc report). Due to time, an anticipated discussion of risk adjustment did not occur.

## Wrap Up and Adjournment

Meeting adjourned at 12:00 p.m.

## Next meeting

Tuesday, March 1, 2022

Meeting to be held on Zoom

10:00 a.m. – 12:00 p.m.

Advisory Committee on Data Issues

Meeting Minutes

01/31/2022